PRINTED: 08/09/2018 FORM APPROVED OMB NO. 0938-0301

MALEMENT OF DESIGNATION	(X1) PROMPERSON			OMB NO. 0938-03
ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED
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E 000 Initial Comments		E 000		
An emergency preparation of the conducted from 07/1	aredness survey was 11/18 through 07/13/18.			
The findings of the su interviews and the re preparedness progra	urvey were based on view of the emergency im.			
Note: The below are appear throughout the	abbreviations that may e body of this report.			
COOP/EP - Continuity Manual/Emergency P DSP - Direct Support EP - Emergency Plan EPP - Emergency Pre QIDP - Qualified Intelle Professional RC - Residential Coord	reparedness Plan Professional paredness Program ectual Disabilities			
006 Plan Based on All Haz. CFR(s): 483.475(a)(1).	ards Rick Associant	E 006		
[(a) Emergency Plan. T and maintain an emerg that must be reviewed, annually. The plan must	The [facility] must develop gency preparedness plan and updated at least st do the following:]			
 Be based on and inc facility-based and commassessment, utilizing ar 	clude a documented, nunity-based risk n all-hazards approach.*			
community-based risk a all-hazards approach, in	icluding missing residents.			
and moldace a document				
ORY DIRECTOR'S OR PROVIDER/SU	IPPLIER REPRESENTATIVE'S SIGNAT	URE	A I TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TILD11

Facility ID: 09G056

If continuation sheet Page 1 of 12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1

t) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

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NAME OF PROVIDER OR SUPPLIER

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07/13/2018

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

STREET ADDRESS, CITY, STATE, ZIP CODE

WASHINGTON, DC 20011

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E 006 Continued From page 1

community-based risk assessment, utilizing an all-hazards approach, including missing clients.

- (2) Include strategies for addressing emergency events identified by the risk assessment.
- * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the EPP included strategies that addressed facility and community based disasters identified in the risk assessments, for five (5) of 5 clients in the facility (Clients #1, 2, 3, 4, and 5).

Findings included:

On 07/13/18, at 10:10 AM, the Administrative Assistant and QIDP said that the agency began developing a comprehensive emergency plan in November of 2017. The QIDP stated that the strategies for addressing emergency events/disasters in the facility and community based risk assessment were not outlined in the COOP/EPP.

On 07/13/18, at 10:27 AM, review of the facility's COOP/EPP dated November 2017 confirmed the QIDP's interview that specific strategies for emergency events/disasters identified in the facility and community based risk assessment were not outlined in the COOP/EPP.

E 006

The facility is working on updating strategies for addressing emergency events/disasters in the community. Such updates will be incorporated in the facility's Continuity of Operations Plan (COOP) and Emergency Preparedness Plan (EPP).

09/06/18

Staff will be trained on the updated strategies for addressing emergency events/disasters. The facility's QIDP will train staff quarterly on the updated strategies.

09/06/18

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addressed facility an	rvey, the facility failed to included strategies that d community-based the risk assessment.	E 009	6	
that must be reviewed annually. The plan must be processed to maintain an integrated disaster or emergency documentation of the such officials and, whe participation in collaboration planning efforts. * [For ESRD facilities of include a process for collaboration with local federal emergency presonantain an integrated disaster or emergency documentation of the disaster or emergency documentation of the disaster or participation in collaboration planning efforts. The disaster or emergency present the local emergency present annually to confirm of the dialysis facility's nemergency. This STANDARD is not	for cooperation and al, tribal, regional, State, and reparedness officials' efforts ted response during a resituation, including facility's efforts to contact en applicable, of its rative and cooperative and separedness officials' efforts ed response during a situation, including facility's efforts to reduce the regional of the response during a situation, including facility's efforts to reduce the reparedness officials, of its end, when applicable, of its eative and cooperative elysis facility must contact eparedness agency at that the agency is aware eeds in the event of an		 The facility is working of developing policies and procedures incorporating collaboration with local, regional, state and federal Emergency Plan (EP) officials to ensure an integrated response during a disaster. Staff will be trained on the updated policies and procedures. The facility's QIDP will be training staff quarterly on the updated policies and procedures. Policies and procedures developed on collaboration with local, regional, state and federal Emergency Plan (EP) officials will be incorporated in the facility's COOP/EPP. 	g 09/06/18

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failed to ensi- local, refforts disaster facility Finding On 07/1 an internot confederal respons situation On 07/1 COOP/E that the state and integrate emerger At the tin that the find that ensu- local, regions.	egional, state to ensure an ar, for five (5) of (Clients #1, 2, s included: 13/18, at 10:10 view that the tacted the located the located the located defining a district collaboration of the survacility development of the survacility development cooperational, state an incomplete the cooperational, state and incomplete the cooperational of the survacility development cooperational, state and incomplete the cooperational of the survacility development of the sur	tten policies and procedures on and collaboration with and federal EP officials integrated response during a of 5 clients residing in the	E 009		
E 015 Subsister	mu/or emerge	ency. Staff and Patients	E 015		

[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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E 015 Continued From page 4

this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:

- (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies
- (ii) Alternate sources of energy to maintain the following:
- (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
 - (B) Emergency lighting.
- (C) Fire detection, extinguishing, and alarm systems.
 - (D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.

- (6) The following are additional requirements for hospice-operated inpatient care facilities only The policies and procedures must address the following:
- (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
- (A) Food, water, medical, and pharmaceutical supplies.
- (B) Alternate sources of energy to maintain the following:
- (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
 - (2) Emergency lighting.

E 015

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(X5) COMPLETION DATE

E 015 Continued From page 5

(3) Fire detection, extinguishing, and alarm systems.

(C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop written policies and procedures that addressed subsistence needs, including food, alternative light sources, water, pharmaceutical supplies and sewage for clients and staff during emergency situations, for five (5) of 5 clients residing in the facility (Clients #1, 2, 3, 4 and 5).

Findings included:

On 07/13/18, at 10:10 AM, the Administrative Assistant and QIDP indicated that the agency began developing a comprehensive emergency plan in November of 2017, as required. The QIDP indicated that the strategies for addressing food, water, pharmaceutical supplies, and sewage for clients and staff during emergency situations was documented in the COOP/EPP.

On 07/13/18, at 10:27 AM, review of the facility's COOP/EPP November 2017 did not outline specific strategies for subsistence needs, including water, pharmaceutical supplies, and sewage. While the COOP/EPP reference the seven day supply of food would be in the facility. The plan did not specify how food would be provided if relocation to an alternative site was necessary. The plan did not address other subsistence needs such as alternative light sources, water, pharmaceutical supplies and sewage.

On 07/13/18, at 11:05 AM, the QIDP and the Administrative Assistant confirmed that the

E 015

The facility is working on developing policies and procedures addressing: provision of subsistence needs for staff and patients whether they evacuate or shelter in place, alternate sources of energy to maintain temperatures to protect patient health and safety, safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems, and sewage and waste disposal. Staff will be trained on the above-policies and procedures.

09/06/18

Policies and procedures addressing the aforesaid will be incorporated in the facility's COOP/EPP. The plan will address how food will be provided when residents and staff relocate to an alternative site.

09/06/18

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E 015

E 018

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E 015 Continued From page 6

NAME OF PROVIDER OR SUPPLIER

COOP/EPP had not considered specific strategies as it pertains to the above mentioned COOP/EPP requirements. However, a generic plan had been completed and a specific plan would be developed.

At the time of the survey, there was no evidence that the facility developed policies and procedures that addressed subsistence needs, including water, pharmaceutical supplies, and sewage during emergency situations.

E 018 Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2)

- [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]
- (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and

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	must document the state receiving facility of the receiving and proceeds of evacuees; stransportation; identification(s) and primal communication with elassistance. (v) A system to track the temployees of the receiving on-duty employees of relocated during the elastic the receiving on-duty employees of relocated during the elastic the receiving the receiving the relocated during the receiving the recei	are relocated during the TF's, LTC, ICF/IID or PACE] specific name and location of or other location. ce at §418.113(b)(6):] ares. rom the hospice, which in of care and treatment staff responsibilities; ication of evacuation ry and alternate means of external sources of the location of hospice and sheltered patients in the an emergency. If the sheltered patients are mergency, the hospice pecific name and location of location of the sheltered patients are	E 018			
w tr re e m	reatment needs of eva esponsibilities; transport vacuation location(s):	vacuation from the CMHC,				
do do po	For OPOs at § 486.36 rocedures. (2) A syste ocumentation that presonor information, protected and actual donor occurs actual donor occurs and actual donor occurs actual donor occurs and actual donor occurs actu	m of medical serves potential and actual ects confidentiality of	ě			

secures and maintains the availability of records.

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E 018 Continued From page 8

*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures to track the location of staff and sheltered clients during an emergency, for five (5) of 5 clients residing in the facility (Clients #1, 2, 3, 4 and 5).

Findings included:

On 07/12/18, at 12:52 PM, DSP #1 was asked about the facility's method for tracking the location(s) of staff and sheltered clients during an evacuation. DSP #1 said facility staff would take a head count. DSP #1 stated that if the clients had to evacuate the facility, they would relocate to a hotel and/or Brooklyn Senior day services, call management staff and let them know where they were sheltering in place. At 11:33 AM, DSP #2 was asked about the facility's method for tracking the location(s) of staff and sheltered clients during an evacuation. DSP #2 stated that a head count would be taken and that she would call management (i.e. RC, QIDP) to let them know there location should they have to evaluate from the facility.

On 7/13/18, beginning at 10:10 AM, the QIDP said during an interview that there was no policy on tracking staff or clients. The QIDP said that the policy and procedure for locating staff and clients to include sheltering in place and evacuation during an emergency needed to be added to the COOP/EPP.

On 07/13/18, beginning at 10:27 AM, review of

E 018

E 018

The facility is working on developing policies and procedures on tracking the location of staff and sheltered clients during an emergency. Staff will be trained on the completed policies and procedures.

09/06/18

- A family communication plan (family herein referred to as the facility) will be instituted in guiding staff on how to efficiently communicate with the receiving facility or other location.
- 09/06/18
- The policies and procedures on tracking the location of staff and sheltered clients during an emergency will be incorporated to the facility's COOP/EPP. Staff will be trained on the developed communication plan.

09/06/18

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E 018 Continued From p	age 9	F 040		
the COOP/EPP da	ted November 2017 falled	E 018		
OLIOM CAIDGUE IUS	t the facility had developed dures to address the ongoing			
additing of stiellere	Clients and staff locations			
during and after an	emergency.			
At the time of the s	urvey, the facility failed to			1
doddinent a means	Of tracking the least			
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022 Policies/Procedures	for Sheltering in Place	F 000		
CFR(s): 483.475(b)	(4)	E 022		
(b) Policies and pro	cedures. The [facilities] must			
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accoppinion at Dala	graph (a) (1) of this section, risk graph (a)(1) of this section,			1
and the communicat	IOO plan at paragraph (-)			
reviewed and update	cles and procedures must be			1
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address the following				
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patients, staff, and vo	ns to shelter in place for llunteers who remain in the			1
[facility].	Tomain in the			
*[For Inpatient Hospic	es at §418.113(b):] Policies			
and procedures.				
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The policies and proce	edures must address the			1
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hospice employees wh	er in place for patients, no remain in the hospice.			
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Facility ID: 09G056

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	facility failed to deve that address a mear clients and staff who disaster or emergence clients residing in the and 5). Findings included: On 07/13/18, beginning the facility's COOP/El showed no evidence.	not met as evidenced by: view and interview, the lop policies and procedures is of sheltering in place for remain in the facility during a cy situations, for five (5) of 5 is facility (Clients #1, 2, 3, 4 and at 10:27 AM, review of PP dated November 2017 that the facility had	E 022	E 022 The facility's COOP/EPP/EP will updated to address sheltering in place for clients and staff duri emergency. Staff will trained on the update COOP/EPP/EP with emphasis on sheltering place.	or ng an Il be ed	09/06/1
((On 07/13/18, at 12:33 an interview that staff do should staff and clip place for tornados, poweather, hurricane, etc were policies and proc COOP/EEP for in shell	PM, the QIDP said during had been trained on what to ents have to shelter in wer outage, severe by then asked if there edures outlined in the tering place that was so risk assessment, the eving the policion and				
A th p pl D29 D	at the time of the surve	y, there was no evidence ped policies and addressed sheltering in	E 029			
Ų.) The [facility] must de mergency preparednes	velop and maintain an is communication plan				

that complies with Federal, State and local laws

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PR		& MEDICAID SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			FORM APPROMB NO. 0938- (X3) DATE SURVE COMPLETED
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FOR CONTRACTOR CONTRAC	This STANDARD is Based on interview a failed to develop and communication plan for five (5) of 5 clients or five (5) of 5 clients Clients #1, 2, 3, 4, and findings included: On 07/11/18, beginning aid during the initial incommunication plan for munication plan for emain ould communicate where and/or emain ergency. OOP/EPP November DP's interview that the munication plan incommunication plan incommunication plan incommunication plan incommunication plan incommunication plan incommunication-related ephone numbers. The would be updated in the time of the suppose.	not met as evidenced by: and record review, the facility maintain a written in the facility's COOP/EPP, is residing in the facility and 5). ag at 8:30 AM, the QIDP interview that the clude a formal The QIDP stated that staff ith administrators via if there was an	E 029	E 029	The facility is working or updating the COOP/EPP include comprehensive a communication plan. The facility's QIDP will train staff on the updated communication plan.	to

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. SUILDING:		COM	rte I ED	
	HFD03-134	B. WING		07/	07/13/2018	
NAME OF PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	STATE, ZIP CODE			
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1000: INITIAL COMMENT	rs	1 000				
through 07/13/18. A was selected from a one woman with val disabilities. The findings of the s observations, intervi and administrative r determined that the compliance with the Public Health and M	was conducted from 07/11/18 A sample of three residents a population of four men and rying degrees of intellectual survey were based on iews and review of resident ecords. The survey findings facility was in substantial requirements of Title 22 edicine Chapter 35 Group Is with Intellectual Disabilities. e cited.		TTITLE 22 CHAPTER - THE FACILITY THE REQUIREM OF TITLE 22, CH 35.	MET MENTS	07/13/	

STATE FORM

6889

TILD11

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If continuation sheet 1 of 1

DEPARTMENT OF HEALTH AND I. JAN SERVICES PRINTED: 08/09/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 09G056 B. WING NAME OF PROVIDER OR SUPPLIER 07/13/2018 STREET ADDRESS, CITY, STATE, ZIP CODE COMP CARE II VASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 000 INITIAL COMMENTS W 000 A recertification survey was conducted from 07/11/18 through 07/13/18. A sample of three clients was selected from a population of four men and one woman with varying degrees of intellectual disabilities. This survey was conducted utilizing the focused fundamental survey process. The findings of the survey were based on observations, interviews and review of client and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. LPN - Licensed Practical Nurse POS - Physician's Orders QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse W 368 DRUG ADMINISTRATION W 368 CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client received all medications in accordance with the POS, for two (2) of three (3) clients in the core sample (Clients #1 and 3). Findings included: LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TILD11

Facility ID: 09G056

If continuation sheet Page 1 of 3

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) D	O. 0938-0391 ATE SURVEY DMPLETED
		09G056	B. WING		0.	7/13/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/13/2010
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100 mg	On 07/11/18, at 6:46 showed Client #3 jurconsisted of waffles beverage. At 6:56 At take his plate to the breakfast. At 7:00 At to the facility. At 7:07 AM, observated administration pass administered Client medications. The LF one additional medications. The LF one additional medications. The LF one additional medications. Continued of thirty (30) minutes at LPN then added that Synthroid that was to eating. Continued of showed Client #1 red mouth and at 8:02 At administered Synthroid administered Synthroid during the rivia, telephone. The Lduring the morning meant to say that Synthroid synthroid synthroid synthroid synthroid synthroid synthroid synthroid during the morning meant to say that Synthroid during the morning meant to say that Synthroid synthroi	S AM, morning observation st completed breakfast which turkey sausage and a AM, Client #1 was observed to kitchen sink after completing AM, the morning nurse arrived ations of the medication showed the LPN #1 several different PN said that Client #1 had beation (Synthroid) that he took feer eating breakfast. The at Client #3 also received to be given 30 minutes after observations at 8:00 AM beeived Synthroid 75 mg by AM, Client #3 was bid 100 mg mixed with	W 36	8		

later than usual and that it was his fault for administering the Synthroid medication at 8:00

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CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE IB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G056	B. WING		07/12/2010	
NAME OF	PROVIDER OR SUPPLIER		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	07/13/2018	
COMP			w	ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) BE COMPLETION ATE DATE	
	should have the morand/or the QIDP/LPi medications to the copportunity to admin minutes prior to their On 07/13/18, at 2:47 with the RN that Clie morning medication 8:02 AM when the migiven 30 minutes prior hours after breakfast clients' medications shours after the LPN of administering the preakfast. The RN sall nurses as soon as administration for all.	The LPN further stated that he rning 8:00 AM - 4:00 PM LPN N to administer the slients after he missed the hister the medications 30 r breakfast meals. TPM, the surveyor shared ents #1 and #3 received their (Synthroid) at 8:00 AM and hedications should have been or to eating breakfast or 2 t. The RN said that the should have been given 2 missed the 30 minute window medications prior to stated that he would re-train is possible on medication clients residing in the facility. Vey, the facility failed to d 2 medications were	W 368	W 368 The facility's Registere Nurse (RN) has trained Licensed Practical Nurse (LPNs) and The Trained Medication Employee (TME) on the ten rights medication administration Please see sign-in sheet and agenda for the training TMEs and LPNs will be observed quarterly on implementation of medication administration guidelines.	all ses d s of son. ing. 07/20/18	